No. 97-689

In The

Supreme Court of the United States

October Term, 1997

BONNIE L. GEISSAL as representative of the Estate of JAMES W. GEISSAL, deceased,

Petitioner,

vs.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

REPLY BRIEF FOR PETITIONER

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I. The Statutory Language — When Viewed As A Whole — Supports Petitioners' Position.

The issue in this case is whether the spouse's pre-existing coverage that gave plaintiff under two policies before a COBRA-qualifying event, provides reason to excuse the worker's employer from continuing to assure such coverage. The authorities cited by Respondents support Petitioner's contention that if the language at issue has "a plain and unambiguous meaning with regard to the particular dispute in this case" it is dispositive. *See Robinson v. Shell Oil Co.*, 117 S. Ct. 843, 846 (1997); *Conroy v. Aniskoff*, 507 U.S. 511, 514 (1993); Resp. Brief, at 9. They are constrained to assert that the "plain meaning" of this statute actually supports this interpretation. However, their brief lacks any significant argument concerning the plain meaning of the text. They rely principally[1] on the argument that the language "[t]he date on which the qualified beneficiary first becomes, after the date of the election . . . covered" 29 U.S.C. § 1162(2)(D) was merely intended to pinpoint "the first time when a suspension of coverage can occur." Resp. Brief, at 14. The idea here is that COBRA coverage can only terminate *after* it has begun. The statutory language, it is argued, simply recognizes that COBRA coverage cannot "end" before it has begun — because, Respondent's presume, coverage does not begin until the election date. Thus, the words "after the date of the election" were included solely as a matter of logical consistency. Resp. Brief, at 8.[2] Respondents propose that this interpretation is required if the Court views the legislation:

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1. Respondents also make a half-hearted argument that "Petitioner's husband only **truly** (primarily) became covered by the Aetna health plan when the COBRA was terminated." Resp. Brief, at 14. There is no statutory language which supports Respondent's argument that a person is not "truly covered" within the ordinary meaning of "covered" by a policy that provides secondary or alternative coverage. The language of section 1162(D)(i) recognizes that it is possible to be "covered" by both a COBRA policy and another group health plan which contains an "exclusion or limitation with respect to any preexisting condition. . . ."

2. The Health Insurance Association's brief relies on this same (Cont'd)

> . . . as a whole and not just a snippet. A court must review the whole of an Act to determine a specific provision's meaning and the intent of Congress. *Conroy v. Aniskoff*, 507 U.S. 511 (1993) (Scalia, J. concurring). . . . [Petitioner and amici's] failure to admit that an Act is to be construed in its context is most telling because to recognize the entirety of this most cardinal of cannons.

Resp. Brief, at 9. In fact, viewing the language of the statute as a whole utterly refutes Respondent's argument. The termination provision is part of a subsection defining the "Period of coverage" as "beginning on the date of the qualifying event and ending not earlier than the earliest of" various dates. 29 U.S.C. § 1162(2). Because coverage begins on the date of the qualifying event — and not on the election date — it is not logically necessary for an "election" to precede the termination of coverage: logically, coverage may terminate either before or after the election date, but only *after* the qualifying event.

Petitioner has no quarrel whatsoever with the principle that the statutory language is to be interpreted as a whole. *King v. St. Vincent Hosp.*, 502 U.S. 215, 221 (1991) (*quoting NLRB v. Federbush Co.*, 121 F.2d 954, 957 (2nd Cir. 1941) (L. Hand, J.)).

Thus, it is quite appropriate for the Court to consider the meaning of paragraph 1162(2)(D) in the context of subsection

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(Cont'd)

point for their argument that the language of the act is ambiguous Amicus Brief, at 9-11. Therefore, the association asserts, the statute is subject to "interpretation" using congressional committee reports and public policy arguments. What is interesting about this brief is its artfulness in finding ambiguity in specific statutory language — because it might be misread (but only if one ads the "truly covered" language Respondents believe is implied) as pertaining to the time that other coverage "truly" takes effect, *id.* at 10 — while at the same time — arguing that a committee report is unambiguous because it includes the word "any" in the most generalized statement of intent. *Compare* Amicus Brief, at 11-13 *with* Pet. Brief, at 40-45.

1162(2), as Petitioner has proposed. However, Respondents cannot, by invoking "the significance of context," import into a statute through what Justice Souter aptly describes as "quite circular reasoning" concepts from its own self-serving analysis, legislative documents, or policy arguments. *King*, 502 U.S. at 221-222. When the terms of a statute are unambiguous — as they are in this case — the only "context" that has any significance are other statutory terms. *King*, 502 U.S. at 222 & n.14.[3]

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3. Respondents remarkably rely on *Robinson v. Shell Oil Company*, 117 S. Ct. 843 (1997); *West Virginia University Hospitals, Inc. v. Casey*, 499 U.S. 83 (1990); *Commissioner of Internal Revenue v. Engle*, 464 U.S. 206 (1984), and Judge Scalia's concurrence in *Conroy v. Aniskoff*, 507 U.S. 511 (1993) as support for a somewhat looser application of the "whole statute" approach. *See, e.g.*, 464 U.S. at 217. Resp. Brief, at 9-10, 20. However, in both *Robinson* and *Engle*, the Court was interpreting statutes that it found to be ambiguous. *See* 117 S. Ct. at 848 (Finding that the term " 'employees' . . . is ambiguous we are left to resolve that ambiguity."); 464 U.S. at 216-17 ("The Commissioner's and taxpayers' interpretations do not exhaust the possible readings of this linguistic maze. . . . Each of the possible interpretations . . . can be reconciled with the language of the statute itself."). In fact, these cases illustrate that the Court is reluctant to stray from whatever intent can be gleaned statutory language even to interpret an ambiguous statute. 117 S. Ct. at 848.

In *Conroy*, the Court considered an unambiguous statute and correctly applied the *King* analysis to conclude "the context of this statute actually supports the conclusion that Congress meant what [it said]." 507 U.S. at 515 (*citing King*, 502 U.S. at 221). The *Conroy* Court then resorted to legislative history to confirm that a literal construction was not so absurd or illogical that Congress could not have intended it 507 U.S. at 516-17. In his concurrence, Justice Scalia vehemently condemned this brief diversion into legislative history — and away from the terms of the statute. 507 U.S. at 519 ("We are governed by laws, not by the intentions of legislators.")

In *West Virginia Hospitals*, writing for the Court, Justice Scalia cogently condemned the approach to statutory interpretation advocated

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There is nothing ambiguous here whatsoever: Respondents' argument is completely flawed because the period of COBRA coverage begins at the time of a qualifying event, not at the time of election. The effect of the mistaken reading urged by Respondents would be to render the statutory language in section 1162(2)(D) entirely meaningless, a result which this Court cannot allow. *See United States v. Menache*, 348 U.S. 528, 538-39 (1955); Pet. Brief, at 27.

II. Contrary "Interpretations" in Lower Courts Do Not Imply Ambiguity.

Lacking any significant textual argument, Respondents and the Health Insurance Association rely on the fall-back position that the statutory language must be ambiguous because:

> . . . this section has been reviewed by at least 21 different appellate justices. Sixteen justices determined that the plain meaning of COBRA permitted terminations if there was pre-existing coverage under any other group health plan while five held that it did not.

Resp. Brief, at 19. *See also* Resp. Brief, at 16; Brief of the Health Insurance Association, at 10-11.

(Cont'd)

by Respondents which attempts to find ambiguity on the basis of a supposed inconsistency with a "scheme" of various successive statutory enactments. 499 U.S. at 101 ("But where, as here, the meaning of the term prevents [accommodation with previously and subsequently enacted law] it is not our function to eliminate clearly expressed inconsistency of policy, and to treat alike subjects that different Congresses have chosen to treat differently. The facile attribution of Congressional 'forgetfulness' cannot justify such a usurpation.") *See* Resp. Brief, at 11 (consistency with statutory scheme of Health Insurance Portability Act), 14 (consistency with Americans with Disabilities Act), and 20 (" . . . is there any question that Congress could have been clearer and more comprehensive in drafting the COBRA legislation?" *e.g.* by defining what "covered" means).

It shows how all the judicial interpretations of section 1162(2)(D) relied on by Respondents have grown like a coral reef: polyp-by-polyp — upon the calcarious skeletons of their anthozoan ancestors — by simply adopting the reasoning or dicta of earlier decisions with little or no independent consideration of the statutory language. *See, e.g., Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1462-64 (8th Cir. 1997). Ultimately the original decisions, upon which all the others cited by Respondents grew, either gave no actual consideration to the terms of the statute, *see, e.g. Brock v. Primedica*, 904 F.2d 295, 296 (5th Cir. 1990), or conducted an exercise in lip service to the "plain meaning" rule while actually relying on whatever could be found to support the desired result from the most general and shifting of pronouncements by congressional committee staff members. *See, e.g., National Companies Health Benefit Plan v. St. Joseph's Hospital, Inc.*, 929 F.2d 1558, 1569-71 (11th Cir. 1991).

In *Hubbard v. United States*, 514 U.S. 695 (1995), the Court was recently called on to decide whether to overturn its own 40-year-old unanimous decision interpreting 18 U.S.C. § 6 and 1001, *see United States v. Bramblett*, 348 U.S. 503 (1955), which relied on its own "not completely implausable" 514 U.S. at 706, analysis of the legislative context and historical evolution of that statute. 514 U.S. at 702-703. While noting that historical analysis of previous enactments "should not be discounted for the reasons that may undermine confidence in the significance of excerpts from congressional debates and committee reports," *id.* at 703, the *Hubbard* Court held that "the [*Bramblett*] Court erred by giving insufficient weight to the plain language of 6 and 1001." Ultimately the Court's overriding obligation "to apply the Statute as Congress wrote it", 514 U.S. at 703 (*citing BFP v. Resolution Trust Corporation*, 511 U.S. 531, 570 (1994) (Souter, J., dissenting), was so strong that it surmounted the Court's formidable inhibitions about overturning its own established interpretation of a statute. 514 U.S. at 711 & 712 n.11. However, neither the majority opinion, nor even that of the dissenters in that case, gave any credence to the argument that the prior Court's incorrect reading

of the statutes was any less incorrect — or the plain meaning of the statutes any less plain — because all nine justices in *Bramblett* erred. 514 U.S. at 724 (Rehnquist, C.J., dissenting) (although *Bramblett*'s interpretation of a statute may have been "wrong, even really wrong" it "does not overcome the institutional advantages conferred by adherence to *stare decisis*. . . . This, then, is clearly a case where it is better that the matter be decided than that it be decided right.")

The policy arguments and committee report extracts cited by the lower courts supporting Respondents' position in this case provide a far less persuasive basis for ignoring the plain language of a statute than did the enactment-based reasoning of the nine Supreme Court justices in *Bramblett*. *See Hubbard*, 514 U.S. at 703. In this case, unlike self-referential body of law that has grown up in support of Respondent's position, the courts supporting Petitioner's position reached their decisions through direct and independent analysis of the terms of the statute that precisely govern the circumstances in issue. *Lutheran Hospital of Indiana v. Business Men's Assurance Company of America*, 51 F.3d 1308, 1312 (7th Cir. 1995); *Oakley v. City of Longmont*, 890 F.2d 1128, 1132 (10th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990); *King v. John Hancock Mutual Life Ins. Co.*, 500 N.W.2d 619, 622 (S.D. 1993).[4] The mere existence of contrary authority does not necessarily suggest any ambiguity in the statute: it simply shows that lower courts — are still sometimes misled by extraneous legislative materials — despite this Court's repeated attempts to steer them clear of this kind of error.[5]

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4. Moreover, these cases also represent a " 'competing legal doctrin[e]' that can lay a legitimate claim to respect as a settled body of law." *Hubbard*, 514 U.S. at 713. Accordingly, none of the constraints that made the *Hubbard* Court reluctant to overturn its own earlier unanimous decision should cause the Court any hesitation to overturn erring lower courts on the issues at bar. 514 U.S. at 713 n.13.

5. For additional discussion of these arguments, *see* Petitioner's Brief, at 46-47.

III. Helping Displaced Workers to Get Access to Medical Care Was the Primary Purpose Of COBRA.

Respondents and amici make a great deal of the fact that in enacting COBRA Congress was concerned with the cost burden imposed on employers by the legislation. Resp. Brief at 10-12; 23-25. They assert that the interest Congress was primarily concerned about in enacting — or at least amending COBRA — was reducing the economic impact of continuation coverage on employers[6] by "permitting liberal terminations." Resp. Brief, at 11-12.

Petitioner has no qualms with a presumption that the cost burden on employers was one of the "competing interests" Congress weighed in crafting the terms of the legislation. Resp. Brief, at 10. Any time a piece of legislation imposes a cost, Congress is presumptively concerned — to some extent — about who is going to pay for it. Congress plainly had cost controls in mind when it

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6. As "background" about such costs, the Health Insurance Association includes in its brief some results of a survey which allegedly shows the impact of COBRA continuation coverage. Amicus Brief, at 6-7. These survey results have never been validated, audited, or subjected to any adversarial testing. No information is provided in the survey about sampling methodology — except that there were a very low number of respondents — raising a very real possibility that those companies who responded to the survey are self-selected and not terribly enthusiastic about their responsibilities under COBRA. *See* D. Huff, *How to Lie With Statistics*, 13-21 (1954) ("To be worth much, a report based on sampling must use a representative sample, which is one from which every source of bias has been removed.") The survey does not include any comparison of those circuits (or employers) who allow employees to obtain COBRA despite the existence of pre-existing spousal coverage, with those who do not, nor does it ever define "costs," nor distinguish "administrative" costs from the actual cost of insurance policies. *Id.* at 131-135 ("[W]atch out for a switch between a raw figure and the conclusion."). The Court should be wary of reaching any conclusion from the use of social science data that has not been tested in the adversarial fires of the district courts.

permitted employers — subject to certain caps[7] — to charge ex-employees more for COBRA coverage than the total cost of health insurance prior to a qualifying event.

Nevertheless, the main purpose of COBRA and its amendments was not to reduce the cost burden of employer sponsored health insurance which continued after a qualifying event: there would have been little doubt the legislation would increase this burden to some extent, because before COBRA, employers were not required to provide these benefits. Rather, the primary motivation of the Congressional supporters of the legislation was to reduce those instances in which people are unable to obtain medical treatment due to loss of — or reduction in — insurance benefits following the occurrence of a qualifying event. Pet. Brief, at 40-50.

A recognition of the likely congressional purposes behind the legislation in no way complicates the decision rules that must be followed by this Court: To the extent that it is recognized that Congress was attempting to reconcile diverse purposes in enacting COBRA, "the most reliable guide for that task is the enacted text." *City of Chicago v. Environmental Defense Fund*, 511 U.S. 328, 339 (1994). "Whether Congress has wisely balanced the sometimes conflicting policies underlying [the statute] is not a question that [the Court is] authorized to decide." *Union Bank v. Wolas*, 502 U.S. 151, 162 (1991). If there were any ambiguity to be found in the text, such ambiguity would be resolved bearing in mind that Congress enacted COBRA as a "humanitarian and remedial" measure for the benefit of employees, not as a cost saving legislation for businesses and employers. *A.H. Phillips v. Walling*, 324 U.S. 490, 493 (1945).

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7. Congress did not impose such caps when it passed the Health Insurance Portability Act of 1996, Pub. L. No. 104-191. Consequently, such replacement coverage is usually unaffordable to persons who might otherwise qualify for it. In addition, some insurance companies have been accused of making this insurance difficult or impossible to obtain. This is one reason why COBRA remains such an important benefit.

IV. Respondents' Assertions Regarding Windfalls; Double-Recoveries; Gaps; Secondary Coverage; and Standing Are Not Supported By The Record.

A. Respondents Mischaracterize the Record and Procedural History of this Case.

Respondents base a number of arguments on specific factual assertions about Petitioner's claims, and Respondents' duties to pay those claims versus Aetna — the health insurance provider under Ms. Geissal's group health plan. They assert that "[b]ased upon the discovery supplied by Petitioner and Aetna Health Plans," Aetna paid all of Petitioner's "covered expenses," and that "Petitioner has never made a claim that Aetna failed to pay any medical bills." Resp. Brief, at 6. The only difference between the Moore Medical policy and the Aetna policy, Respondents submit, is a $350 deductible. They posit that the effect of requiring Moore Medical to provide coverage to Petitioner would be "double recovery" — an absurd "windfall" for a few beneficiaries that could not have been intended by Congress. Resp. Brief, at 23. They assert that this means that there was no "significant gap" between the plans, which would preclude coverage by both plans under the lower court decisions that Respondents wish this Court to follow. Resp. Brief, at 25-27. Alternatively, respondents argue that if they were required to give coverage, the Court should hold that they were the secondary insurer, and therefore not required to pay any of Petitioner's claims. Resp. Brief, at 28-29. Moreover, because — in Respondent's opinion — Petitioner could gain no substantial benefit from maintaining this suit unless Petitioner gained a "double recovery" — which presumably violates some legal doctrine — it is asserted that Petitioner has no justiciable interest to give her standing to maintain this suit. Resp. Brief, at 30.

What is ignored in this cascade of factual assertions and arguments is a recognition of what issues are and are not before the Court, what facts are and are not a matter of record, and a recognition of the procedural status of the case as it reaches the

Court: While the case was pending in the district court, Petitioner — and not Respondents — submitted a Motion for Partial Summary Judgment on the sole issue of whether Respondents were obligated to provide COBRA coverage. Petitioner's Motion did not touch on what claims Respondents would be required to pay if Respondents were found to have this obligation. App. at 25a.

Petitioner argued that he was entitled to benefits as a matter of law because he had acquired no other insurance following the occurrence of a qualifying event. App. at 26a. In the alternative, Petitioner claimed that he was entitled to coverage by Moore Medical because

> a person in [Petitioner's] state of health would not have reason to believe coverage only under the preexisting spousal coverage was adequate at the time of or following the 1163 qualifying event.

App. at 26a. In support of the sole proposition that Mr. Geissal reasonably believed the Aetna policy might not be adequate, Petitioner submitted a brief affidavit, executed while he was still in the course of treatment, pointing out that he expected that his cancer would require expensive treatment, that coverage under the plans was different, that because of his illness there was a possibility that he would exceed the lifetime maximum under the Aetna plan, and that he was concerned about the reliability of the insurance under the Aetna plan. App. at 28a-32a.

In response to Petitioners' Summary Judgment motion, Respondents disagreed with Petitioner's substantive legal arguments. Respondents also asserted affirmatively without any supporting evidence that Aetna was a necessary party — and that Geissal did not have standing to pursue his claims. It was only after the parties fully briefed and submitted evidence in relation to the Motion that Mr. Geissal died, and his treatment ceased.

The district court rejected Respondent's affirmative defenses. The court found that Petitioner's equitable interest in COBRA coverage was sufficient to support standing. It also found: (1) that it was irrelevant to the issue of relief between the parties that Aetna may have paid for some of Mr. Geissal's medical treatment; (2) that Aetna did not become a necessary party simply because there was a "speculative possibility" that Aetna might have future claims to the potential proceeds of Petitioner's COBRA policy; and (3) that the question of whether the Moore or Aetna plan should be considered "primary" could be made "upon adequate [future] discovery, without Aetna's presence as a party."[8] App. at 41a-44a.

Unfortunately, the district court also decided at that time to grant summary judgment to Respondents, on the court's own motion, without prior notice to the parties, or any opportunity to submit further evidence bearing on the legal theory it decided to adopt. App. at 35a. On the law, the court found itself in unexplained agreement with *National Companies* conclusion that it could interpret away the plain meaning of the statute, and that COBRA coverage would terminate if a qualified beneficiary had pre-existing spousal coverage. App. at 48a. The court also found that the allegations in Mr. Geissal's affidavit were not sufficient to show a "significant gap" because they did not show that the Aetna policy

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8. Respondents do not contest the district court's finding that Aetna was not a necessary party. In a footnote, Respondents note that Petitioner did not contest this part of the district court's decision, and that she therefore "waived" this issue. Resp. Brief, at 30 n.15. Petitioner has no problem with the district court's finding that Aetna is not a necessary party.

Under Supreme Court Rule 15.1 and *Oklahoma City v. Tuttle*, 471 U.S. 808, 815-16 (1985), the Respondents are to put procedural issues contended to be dispositive of the case, in their opposition to the Petition for Writ. Respondents' concerns that the Petitioner is not the real party in interest (which encompasses their standing and Rule 19 objections) were not in their opposition and were therefore waived.

had an exclusion or limitation with respect to a pre-existing condition. App. at 51a.

Considering the state of the record, and the procedural posture of this case, the Court cannot assume any of the facts that Respondents have asserted to support their arguments. No proof exists in the record about (1) whether Petitioner submitted all of his medical expenses to Aetna for payment; (2) whether Aetna paid all Petitioner's expenses; (3) whether Respondent's policy would cover medical expenses not covered by Aetna; or (4) how Respondents and Aetna would coordinate their responsibilities for Mr. Geissal's medical expenses if Respondents were found to be obligated to provide coverage. These issues were not before the court on Petitioner's summary judgment motion, and Petitioner was under no obligation to submit any evidence as part of this motion bearing on these issues. Under the theory Petitioner advanced in support of his summary judgment Motion, all such evidence would be unnecessary: the dispositive issue was either the plain meaning of the law, or whether it was reasonable for him to elect COBRA coverage when he did.[9]

B. The Record Does Not Reveal Anything About The Nature of Petitioner's Claims, Coordination of Benefits Between Policies, and What "Gaps" May Remain in Coverage.

The procedural status of the case when the district court made its ruling both defines and limits the relief that this Court may provide. If the Court upholds the plain meaning of the statute, it can rule that Respondents were required to provide coverage, but cannot determine which claims they are obligated to pay because no evidence bearing on this was before the district court. The Court also cannot make any substantive determination about which insurance policy would be "primary" and which "secondary" — because this issue was not before the district court when it ruled.

9. Petitioners dispute Respondent's assertions with respect to these factual issues.

Similarly, the Court can determine whether the statute authorizes a "significant gap" test, and can set guidelines as to how the test can be applied — but it cannot rule as to the outcome of that test (assuming *arguendo* that any such is to be applied) because Petitioner has not yet been given the opportunity to introduce evidence that a significant gap existed.

Viewed in light of the above observations, Respondents' arguments regarding "double recoveries," and "windfalls" are entirely illusory. Respondents have proven nothing about their obligations to pay Petitioner if they are required to provide COBRA coverage.

C. Respondent's Observations Are Irrelevant.

Respondents' may or may not be able to show — at some point — that their obligations to pay some claims under their insurance contract are limited — to some extent — by virtue of the Aetna coverage, but that possibility has no bearing on the entirely separate question of whether or not they are statutorily obligated to provide COBRA coverage at all. Aetna may or may not have claims against Petitioner if Respondents are obligated to pay for medical expenses already paid by Aetna. But, as the district court correctly held, that is a matter between Aetna and Petitioner, which does not concern Respondents, who is not a necessary party of this litigation. App. at 44a (*citing LLC Corp. v. Pension Benefit Guarantee Corp.*, 703 F.2d 301, 305 (8th Cir. 1983)).[10] Assuming

10. The district court's finding that Aetna was not a necessary party to this litigation is fatal to their claim that Petitioner lacks standing. App. at 29. Petitioner can enforce his right to COBRA coverage — and to obtain benefits under a COBRA policy "without regard to the speculative possibility of future litigation" between Petitioner and Aetna. Respondents assert that Petitioner's motivation for bringing this suit is "highly suspect" in view of what they allege about Aetna's payments. Resp. Brief, at 29. There would be nothing improper about Petitioner seeking to recover all benefits she would be entitled to under the Moore

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that Respondents are required to provide coverage under COBRA, their obligations to Petitioner would be no greater than what they would have been if Moore Medical had not terminated Mr. Geissal.[11] Nothing about this result not absurd,[12] but it appears to be exactly

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Medical Plan, even assuming *arguendo* that she is also entitled to recover for some of the same expenses under the Aetna Plan, or that she is pursuing this litigation — in part — as a nominee for Aetna.

11. It would not be necessary for the Court to alter the plain meaning of statutes, or the statutorily mandated results of a given case, to avoid the possibility of "double recovery" for medical expenses — even if there was some valid argument to support an alternate construction. If the sponsors of group health plans wish to avoid this possibility, nothing prevents them from drafting group health plans to disallow double recovery. Respondents appear to be urging the Court to read into the terms of a statute what they worry they might have forgotten to add to the terms of their own insurance policy.

12. Respondents posit several other possible scenarios which allegedly show that interpreting the statute consistent with its plain meaning would yield absurd results. Resp. Brief, at 20-21. In both of these unusual circumstances, a qualified beneficiary is able to gain COBRA coverage even though he or she elects other group health care coverage after occurrence of a qualifying event. Respondents are unable to point to any case in which a potential beneficiary has tried to obtain secondary coverage in the manner they suggest, and it is extremely doubtful that the average COBRA beneficiary would go to so much trouble to fit herself into a loophole in the act in order to gain secondary coverage after a qualifying event. Moreover, the results are not really absurd, bizarre, or even contrary to Congress's intent to assist families who experience qualifying events. Pet. Brief at 31-33. At most these scenarios show that it is possible under the statute for someone to gain secondary coverage while retaining COBRA benefits under circumstances that Congress did not fully anticipate. "The fact that Congress may not have foreseen all of the consequences of a statutory enactment is not a sufficient reason for refusing to give effect to its plain meaning." *Union Bank v. Wolas*, 502 U.S. at 158 (*citing, Toibb v. Radloff*, 501 U.S. 157, 164 (1991)).

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what the Congressional supporters of COBRA intended. *See* H.R. Rep. No. 99-241, pt. 1, at 44, *reprinted in*, 1986 U.S. Code Cong. & Admin. News 579, 622 (noting the Committee's desire to make coverage to a discharged employee under COBRA "identical in scope to the coverage provided under the group plan to similarly situated individuals in the group."); Cong. Rec. H38286 (daily ed. December 19, 1985) (Conference Report on H.R. 3128 and 3500).

D. Respondents Misconstrue Petitioners' Position on the "Significant Gap" issue.

Respondents argue that Petitioner has waived the issue of how the Courts should approach the determination of whether or not there is a "significant gap" in coverage in applying the statute at issue. Resp. Brief at 25. She did not. She asserts that a "significant gap" test should not be used by the courts at all in cases where there is pre-existing group health care coverage.[13] Pet. Brief, at 36, 45, 48-49. In Petitioner's view, the law anticipates that it is up to the qualified beneficiary to apply their own "significant gap" test when they decide whether to elect COBRA coverage — and the Courts should respect this choice. H.R. Rep. No. 101-247, 101st

(Cont'd)
In contrast, under the analysis advocated by Respondents, if an otherwise qualified employee had, at the time of termination, secondary spousal coverage that is plainly insufficient for serious medical problems (*e.g.* $5 per medical event, an annual maximum of $500, and a lifetime maximum of $1500) without a clause excluding specific pre-existing conditions, there could be no "significant gap" allowing him to obtain COBRA coverage. This type of result is both far more bizarre — and more probable — than any hypothetical absurdity Defendants have proposed.

13. Whether a "significant gap" test is a useful framework for deciding if there is an "exclusion or limitation" 29 U.S.C. § 1162(2)(D)(i) preventing coverage for pre-existing condition in a group health plan acquired after the date of a COBRA election is beyond the scope of this case.

Cong., 1st Sess., *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 1943 ("If the qualified beneficiary is willing to elect health insurance continuation coverage from a previous employer as well, that is a strong indication that the new employer has left a significant gap in coverage.") It would be irrational for qualified beneficiaries to pay for health care coverage that they did not have a good reason to want.

Respondents have proposed an alternate version of the significant gap test that would allow — first a plan administrator, and then the Courts — to decide whether there "was" a significant gap by reviewing a beneficiary's claims after the fact to determine whether there was an exclusion or limitation on a pre-existing condition. We have discussed the difficulties inherent in this approach, and argue not only that there is no support for it in the enactment, but that it is a horribly bad idea. Pet. Brief, at 35.

If, notwithstanding our arguments, the Court concludes that lower courts or plan administrators are compelled (by something Petitioner may have overlooked in the terms of the statute) to get into the business of second guessing employee COBRA elections, they should be doing it from the point of view of the employee at the time of the election,[14] not from the point of view of employers after the fact. Specifically, they should be asking the question that Mr. Geissal asked in his summary judgment motion:

> [Would] a person in [Petitioner's] state of health [at the time of election] have reason to believe coverage only under the preexisting spousal coverage was

14. The Eighth Circuit recognized the advantages of applying the "significant gap" test from the point of view of the day of COBRA election, instead of after the fact. *Geissal*, 114 F.3d at 1465. Unfortunately, it also required it to be applied based on the "information available to the employer" on that day. It would be bad public policy to require ex-employees to disclose their private projections about their own future medical condition to their ex-employers as a condition of receiving continuation coverage after the termination of employment.

> adequate at the time of or following the 1163 qualifying event?

App. at 26a.

Aside from being more workable than anything Respondents have proposed, this test, at least has several conceivable policy advantages: (1) it allows the courts and plan administrators — at their own risk — to protect employees from making completely idiotic COBRA elections; and (2) there will be far fewer circumstances giving rise to cases like this one.

In this case, Mr. Geissal believed it made sense for him to elect coverage when he was terminated from his job, at minimum, because of the tremendous costs of anticipated cancer treatment, the uncertainties of being covered under a single policy, and the lifetime maximums he faced on his wife's group coverage. These concerns are understandable, notwithstanding Respondent's representations about the outcome. The Court should not require Mr. Geissal or other COBRA beneficiaries to anticipate medical outcomes with 20-20 foresight as a condition of COBRA coverage, or to make a perfect choice when they make COBRA elections. If they are going to evaluate these choices at all, courts should be concerned solely that the choices were reasonable. Mr. Geissal's choice was reasonable.

Respectfully submitted,

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